DOCUMENT RESUME

ED 295 086 CG 020 826

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TITLE Spokane Community Mental Health Center--Elderly Services.
INSTITUTION Spokane Community Mental Health Center, WA.
PUB DATE 20 Jan 88
NOTE 25p.; Paper presented at the Annual Meeting of the American Society on Aging (34th, San Diego, CA, March 18-22, 1988).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Caseworker Approach; Client Characteristics (Human Services); *Community Services; *High Risk Persons; *Home Programs; *Interdisciplinary Approach; *Mental Health Programs; *Older Adults; Program Effectiveness

ABSTRACT

This document describes services for the elderly provided by the Spokane Community Mental Health Center (CMHC) in Spokane, Washington. It begins by stating several reasons that the elderly are often unserved or underserved by health and social service agencies and by noting the need for community efforts to identify and locate the subpopulation of isolated, resistant, high-risk elderly persons who are living in their own homes and who do not self-refer for community services. Characteristics of the 538 elderly persons served by the Spokane CMHC multidisciplinary in-home evaluation, treatment, and case management program in 1986 are presented; demographic and clinical data on the chronically mentally ill elderly served are included. Other sections describe program structure and funding; telephone information and referral services; the multidisciplinary in-home evaluation, treatment, and case management program; location of high-risk elderly; in-home assessment and evaluation; treatment and service plans; the program's relationship with other agencies; and program results. Thirteen references and five data tables are included. (NB)

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Spokane Community Mental Health Center

Elderly Services

CG 020826

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January 20, 1988

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Background and Philosophy

The Spokane Community Mental Health Center (CMHC) is a comprehensive mental health center providing services to residents of Spokane County, Washington. This includes all services mandated by the National Institute of Mental Health (NIMH) with particular emphasis on target groups.

According to the 1980 census of population there are 341,058 persons living within Spokane County and of that number 54,000 (almost 16%) are sixty (60) years of age and older and 95% of them are living in their own homes or apartments.

Since 1978 the Spokane CMHC has manifested a strong commitment to serving the elderly population of Spokane, those in their own homes as well as those in long-term care facilities. The Spokane CMHC has had a special concern for those persons over 60 whom the Federal Council on Aging calls the "frail" or "vulnerable" elderly and whom we in mental health call the "moderately to severely dysfunctional." The Spokane CMHC, through a very close working relationship with the Eastern Washington Area Agency on Aging, has operationally blended the mandates from both the Administration on Aging (AOA) and the National Institute of Mental Health (NIMH).

The moderately to severely impaired elderly who live in their own homes have been traditionally grossly unserved by community based agencies. Prior to 1978 only 4% of the active clients of this CMHC were 60 years of age and

older. In November of 1987, however, 22% of the active clients of this CMHC were 60 years of age and older.

The reasons why the elderly are unserved and underserved are several.

1. Health and social service agencies have not understood and/or appreciated the community organization (Gatekeepers) effort necessary to identify and locate this large subpopulation of isolated, resistant, high-risk elderly -- especially those who have no family or personal support system to act on their behalf (Knight et al., 1982).

2. Community-based agencies continue to expect members of target populations to have sufficient insight and motivation to access themselves to needed services. The myriad of single service agencies makes it extremely difficult even for the highly functional to accomplish this (Wylie & Austin, 1978).

3. For some years now we have heard that the reasons high-risk elderly are unserved and underserved lie at the door of the "system". It has been fashionable to explain lack of service as problems of access, physical barriers, bureaucratization of agencies, specialization of agencies, fragmentation of human problems, etc. As important as these "system" problems are, they fail to take into account other highly related factors the most important of which is the at-risk population's resistance to intervention (Cantor & Mayer, 1978). This resistance to use needed services results from reactions to the multiple losses they

experience. As many elderly experience physical, cognitive, emotional, social and economic loss and subsequent decline in function, they tend to minimize and/or deny the existence or severity of these problems. This denial of loss reinforces any isolation they may be experiencing and many of them also have feelings of fear, suspicion, shame and depression which then leads to further isolation and resistance to anyone's intervention, especially agency intervention. Many of them fear that if someone should discover how poorly they are functioning, what little control they do maintain over their lives will be taken away and they will be removed from their home and placed in a nursing home (Hayslys et al., 1980).

We believe that there is a complex relationship between "system" problems and the resistance of the at-risk population and that this inter-relationship has contributed much to the lack of services to this group (Comptroller General, 1979; Toseland et al, 1979).

Lastly, it has been our experience that most moderately to severely impaired older adults do not self-refer for community based services. During program year 1986 only 1% of all persons admitted to our in-home case management program were self-referred.

Characteristics of Population Served

Of the 538 elderly admitted to the multidisciplinary in-home evaluation, treatment and case management program in 1986, 62% were female and 38% male, while 5% were members of minority groups. Only 5% had ever had

any prior outpatient or inpatient psychiatric care which provides some evidence of late-life onset of mental illness (Cohen, 1982; Rosen & Rosen, 1982).

During the intake process, clients were assessed to determine if any significant problems are present. These problems include all areas of functioning and are taken from a list of 52 possibilities. The 538 clients presented such problems as chronic physical illnesses (71%), social isolation/support system (69%), personal care/activities of daily living (62%), emotional depression (56%), environmental/social stress (67%), denial of illness/problems (60%), and memory impairment (59%).

One large group brought to our attention consists of older persons presenting with signs and symptoms of dementia but who live alone and have no caregiver or support system. In December of 1987 a total of sixty-seven persons were admitted to the multi-disciplinary evaluation, treatment and case management program. A review of the presenting problems reveals that the major reasons for referral included thirty (45%) for signs and symptoms of dementia, twenty (30%) for symptoms of major depression, and seventeen (25%) for all other reasons. Of the thirty referred with symptoms of dementia, only fourteen or 47% had a family or caregiver support system. Of the twenty referred with symptoms of major depression, thirteen or 65% had a family or caregiver support system.

The above is further evidence of the multiple and interrelated nature of the problems experienced by at-risk elderly (Gurian, 1982).

The chronically mentally ill elderly, exclusive of dementia, comprise a large number of community-based elderly being seen in their homes by this program. Four diagnostic subgroups, schizophrenia, major depression, bipolar affective disorder and late-life paraphrenia or paranoid disorders, have been identified, and the clinical charts for a sample of each subgroup have been surveyed. The demographic and clinical data appear in Tables 1 and 2.

Insert Tables 1 and 2 about here

Program Structure and Funding

The Spokane Community Mental Health Center's elderly services is composed of two highly integrated component programs: Telephone Information and Referral; and Multidisciplinary In-Home Evaluation, Treatment and Case Management. Each component program receives approximately 60% of its funding from the Eastern Washington Area Agency on Aging. The remaining funds come from Washington State Mental Health Grant-in-Aid, as well as the National Institute on Drug Abuse.

In addition to the above, we have a National Institute of Mental Health funded practicum program for graduate social work students from Eastern Washington University.

Telephone Information and Referral

The Telephone Information and Referral component, staffed by three telephone screeners, is highly visible on a county-wide basis and provides telephone information and referral services targeted at higher functioning older adults. It is only this I & R component that is advertised via posters, brochures, and the local media. Calls are diverted to the Community Mental Health Center Crisis Services after 5 p.m. weekdays and on weekends to provide 24-hour service. This also provides 24-hour access to the in-home case-management component.

The Telephone Information and Referral component directly serves those elderly persons who are experiencing no dysfunction or mild dysfunction, or persons who have support systems willing and able to act on behalf of an elderly person in need who is not experiencing moderate to severe psychiatric and/or cognitive impairment.

Multi-Disciplinary In-Home Evaluation, Treatment and Case Management

The In-Home Case Management component is mandated to maintain the independence of the elderly, to prevent premature and/or unnecessary institutionalization, and to improve their quality of life. The staff of this component consists of the following:

Fifteen case managers who are trained as generalists and carry primary case responsibility;

Five field supervisors, four of whom are registered nurses;

Psychiatrists provide 35 hours a week of in-home evaluation and treatment;

Resident physicians from Family Medicine of Spokane (a residency program of the University of Washington) who provide four hours a week of in-home evaluation and treatment;

One program coordinator who has a master's degree in social work; and

One program director (see Table 3).

Insert Table 3 about here

Use of Gatekeepers to Locate High-Risk Elderly

In addition to education, the public school system has long been identifying troubled children. The workplace, through employee assistance programs, increasingly assumes the role of identifying troubled adults. Gatekeepers attempt to create a system that functions for high-risk elderly living in the community as the schools and the workplace function for younger people. Gatekeepers also overcome the problems of delivery that are so much a part of contemporary social and health services.

Gatekeepers are nontraditional referral sources trained to identify and locate high-risk elderly living in the community who would not self-refer and who do not have relatives or others to act on their behalf. They are corporations, businesses, and other organizations that have contact with the most isolated elderly in the community.

Establishing a gatekeeper system requires a systematic community organization effort. We have found these corporations and organizations eager to allow regular access to their employees once it is understood how important such organizations are to a community-based long-term care system. Ongoing scheduled training, communication after referral, and the ability to effectively work with those who are referred are essential to maintaining a gatekeeper system.

The gatekeeper system that was established includes: meter readers, credit office workers, and repair personnel from the electrical and natural gas utility; residential property appraisers from the county assessor's office; trust officers and other bank personnel; apartment and mobile home court managers; postal carriers and postal workers; water meter readers from the City of Spokane; fuel oil dealers; police and sheriff's departments; fire departments; pharmacies; and ambulance companies.

As an index of success, gatekeepers now account for four out of every ten admissions to the in-home case-management component (see Table 5).

Insert Table 5 about here

In-Home Assessment/Evaluation

After an at-risk older adult has been admitted to the in-home case-management component, the first task is to provide that person with a

comprehensive in-home assessment of his or her functioning (Wasson et al., 1984). Staff members have become highly skilled in establishing positive relationships with the elderly and overcoming the initial resistance expected from many older persons who are fearful, suspicious, or hostile. It is this relationship that provides the conduit for the assessment, services plan, and continuity of care.

The case manager and field supervisor jointly conduct the initial home visits, begin the evaluation and, as needed, the following also make home visits with this staff and provide additional evaluation and treatment: staff psychiatrist and physicians from family medicine. These staff members, with the case managers, comprise the in-home multi-disciplinary team approach we have developed.

The five field supervisors have a very special role vis-a-vis the case managers. Each supervises three case managers on a full-time basis and does not maintain a separate caseload. They field-train the case managers, accompany them on home visits to assist in the assessment process, and provide daily backup measures to resolve the difficult issues inherent in serving this population.

Treatment/Service Plan

Based on the comprehensive assessment of functioning, a detailed service/treatment plan is developed for each client. Elements include medical, psychiatric, socioeconomic, environmental manipulation, and

medications. When support systems exist, these are used to their full potential. Family conferences are held whenever appropriate and feasible (Reed, 1980). A system of care-giver support groups for families caring for a member with a dementing illness also has been developed in conjunction with the Greater Spokane Chapter of the Alzheimer's Disease and Related Disorders Association.

Because of the relationship with the Eastern Washington Area Agency on Aging and written agreements with other agencies funded by that organization, a network of preventive, supportive, and rehabilitative in-home services can be delivered. The services most often utilized and believed to be indispensible to the mission include chore-homemaker services, visiting nurses and nurse aides, day health/day care, home-delivered meals and respite care. Elderly Services is the "front door" in this system (see Table 5).

The interrelated elements of the case-management approach we use include: identification and location of the target population (gatekeepers); crisis intervention; assessment/evaluation; a service/treatment plan; family work; supportive therapy; coordination of services (networking); advocacy; and continuity of care.

Primary ongoing case responsibility is maintained for all persons admitted to the program. Forty-nine percent are officially terminated after long periods of stabilization, 20% because of death, 12% after placement in

a long-term care facility and where future discharge back home is ruled out, 11% due to moving from the community, and the remaining 8% for a variety of reasons. Follow-up after official termination of those stabilized clients is maintained by telephone and/or through the network of in-home supportive services initially established by the case manager.

Relationship With Other Agencies

Fourteen written coordination and referral agreements with other agencies, most of which are funded by the Eastern Washington Area Agency on Aging, have been negotiated. These agreements detail each agency's role, referral mechanisms, methods of resolving problems, and how training and other resources are shared.

The core agency in a community-based long-term care system depends on other community agencies for the implementation of much of the treatment/service plan (O'Brien & Wagner, 1980). Some examples of assistance follow:

1. All agencies involved in the cases presented at weekly case staffings held by elderly services are asked to attend those meetings.
2. Chore workers, who perform housekeeping, meal preparation, and other duties, and who spend more time interacting with high-risk elderly than any other agency person, are trained to reinforce the case plan and to report any decline in client functioning. A specially trained and higher paid group of 25 chore workers is selected by the contracting agency, in cooperation with elderly services, to work with behaviorally-disturbed clients. Elderly services staff members provided 20

hours of classroom training on such subjects as dementia, depression, mental status, and medications. These chore workers are part of a multi-disciplinary effort, participate in case staffings, are provided individual case conferences, and are placed in the homes of the most at-risk elderly.

3. Whenever an active elderly services' client is admitted to a hospital, the social services department of the hospital is notified so that it can be involved in discharge planning and can provide proper follow-up care.

4. The Adult Day Health/Day Care Program is a rehabilitative and supportive program operated by Holy Family Hospital and essential to our mission. Elderly services accounts for 64% of all the referrals received by the Adult Day Health Program. Joint home visits are made by staff members, and the psychiatrist treats referred day health clients.

Program Results

Community mental health centers throughout the United States have traditionally under-served persons 60 years of age and older in proportion to their percentage of the general population. The national average has been approximately 4% (Pratt & Kethley, 1980). As of January 1, 1987, 22% of the Spokane Community Mental Health Center's active clients were 60 years of age or older. These are elderly people living in their own homes or apartments.

Minority elders constitute 1.5% of Spokane's elderly population. Five percent of the active clients in our in-home multidisciplinary case management program are minority elders.

Immediately before 1980 and during the early inception of this program, there existed a critical shortage of nursing home beds in Spokane County. Persons were being transported to other parts of the state in order to secure a bed. During the last five years there has been no shortage of nursing home beds in Spokane County. We believe this is at least partly due to the existence of this program and the aging services network which supports it.

The Spokane Community Mental Health Center enjoys a funding and working relationship with the Eastern Washington Area Agency on Aging. This relationship is unique among mental health centers throughout the country. Because of this, mandates from both the National Institute of Mental Health and the Administration on Aging have been effectively blended.

This program has developed a unique method of locating and identifying high-risk elderly who do not self-refer for community based services and who constitute the population most likely to find itself under institutional care if intervention does not occur. The gatekeeper approach of using meter readers, postal carriers, apartment managers, and so on, has been invaluable in identifying high-risk elderly.

The heart of the program is its in-home multidisciplinary approach. Staff psychiatrists and physicians from family medicine make home visits with case managers for the purposes of evaluation, diagnosis, and treatment. Without this, it would not be possible to maintain many elderly in their own homes.

References

Cantor, M.H., & Mayer, M.J. Factors in Differential Utilization of Services by Urban Elderly. Journal of Gerontological Social Work, Fall, 1978, 1, 47-61.

Cohen, G. D. The Older Person, The Older Patient, and the Mental Health System. Hospital & Community Psychiatry, 1982, 33, 101-104.

Comptroller General, Report to the Congress of the United States; Conditions of Older People: National Information System Needed. 1979.

Gurian, B. Mental Health Outreach and Consultation Services for the Elderly. Hospital & Community Psychiatry, 1982, 33, 142-147.

Hayslys, B., Jr., Ritter, M.L., Ottman, R.M., & McDonnell, C. Home Care Services and the Rural Elderly. The Gerontologist, 1980, 20, 192-199.

Knight, B., Reinhart, R., & Field, P. Senior Outreach Services: A Treatment-Oriented Outreach Team in Community Mental Health. The Gerontologist 1982, 22, 544-547.

O'Brien, J.E., & Wagner, D.L. Help Seeking By the Frail Elderly: Problems in Network Analysis. The Gerontologist, 1980, 20, 78-83.

Pratt, C.C. & Kethley, A.J. Anticipated and Actual Barriers to Developing Community Mental Health Programs for the Elderly. Community Mental Health Journal, 1980, 16, 205-216.

Reed, W.L. Access to Services by the Elderly: A Community Research Model. Journal of Gerontological Social Work, 1980, 3, 41-52.

Rosen, C.E. & Rosen, S. Evaluating an Intervention Program for the Elderly. Community Mental Health Journal, 1982, 18, 21-33.

Toseland, R.W., Decker, J., & Bliesner, J. A Community Outreach Program for Socially Isolated Older Persons. Journal of Gerontological Social Work, 1979, 1, 211-224.

Wasson, W., Ripeckyj, A., Lazarus, L.W., Kupferer, S., Barry, S., & Force, F. Home Evaluation of Psychiatrically Impaired Elderly: Process and Outcome. The Gerontologist, 1984, 24, 238-242.

Wylie, M. & Austin, C. Policy Foundations for Case Management: Consequences for the Frail Elderly. Journal of Gerontological Social Work, 1978, 1, 7-17.

Table 1

Chronically Mentally Ill Elderly Maintained in the Community by Elderly Services

Demographic Characteristics of Diagnostic Sub-Groups

	Schizophrenia N=20	Major Depression N=20	BiPolar N=20	Paraphrenia N=20	Total N=80
Sex:					
Male	15%	25%	35%	5%	20%
Female	85%	75%	65%	95%	80%
Age:					
60-64 Years	30%	5%	30%	10%	19%
65-69 Years	30%	25%	20%	15%	23%
70-74 Years	35%	15%	15%	15%	20%
75-79 Years	--	40%	30%	45%	29%
80-84 Years	5%	15%	--	5%	6%
85 Years and Older	--	--	5%	10%	3%
Income:					
$301-$400	60%	10%	25%	30%	31%
$401-$500	15%	20%	20%	25%	20%
$501+	25%	70%	55%	45%	49%
Source of Income:					
SSI	60%	10%	25%	30%	31%
SSA	30%	50%	25%	20%	31%
SSA and Vets	5%	5%	10%	5%	6%
SSA and Retirement	5%	35%	40%	45%	32%
Race:					
Caucasion	95%	100%	100%	90%	96%
Black	5%	--	--	10%	4%
Living Situation:					
Lives Alone	70%	65%	50%	85%	68%
Lives with Spouse	10%	35%	25%	10%	20%
Lives with Adult Children	10%	--	10%	5%	6%
Lives with Other Relative	10%	--	15%	--	6%
Marital Status:					
Married	10%	40%	20%	10%	20%
Divorced	40%	15%	40%	5%	25%
Never Married	15%	5%	--	30%	13%
Widowed	35%	40%	40%	55%	42%
Source of Referral:					
Gatekeeper	30%	5%	40%	45%	30%
Relatives/Friends	15%	25%	15%	10%	16%
Hospital/Physician	50%	60%	40%	15%	41%
Public Agency	--	5%	--	20%	6%
Voluntary Agency	5%	--	--	5%	3%
Self	--	5%	5%	5%	4%
Family/Informal Support System	35%	65%	50%	10%	40%

Table 2

Chronically Mentally Ill Elderly Maintained in the Community by Elderly Services

Clinical Characteristics of Diagnostic Sub-Groups

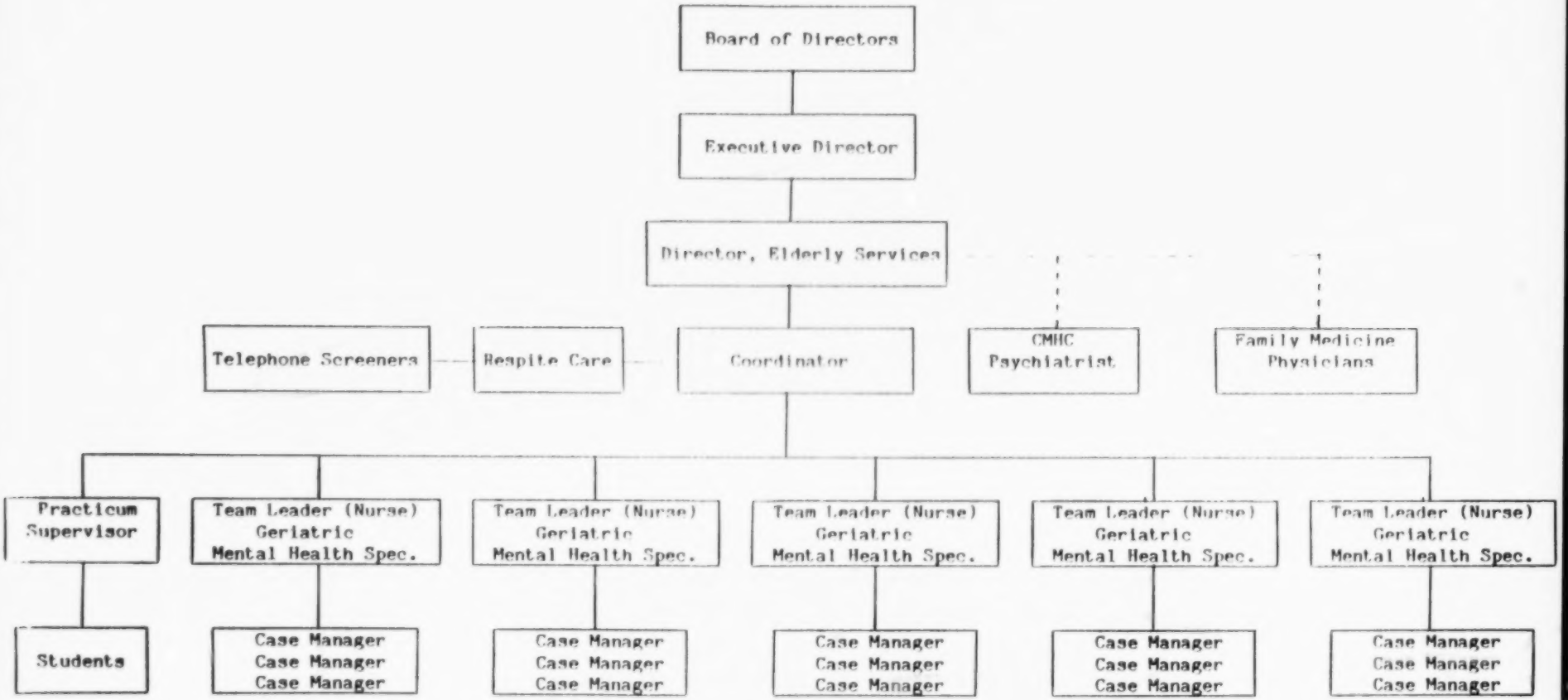
	Schizophrenia	Major Depression	BiPolar	Paraphrenia	Total
	N=20	N=20	N=20	N=20	N=80
Psychiatric Hospitalizations:					
None	5%	25%	10%	45%	21%
One	5%	35%	25%	40%	26%
Two	15%	10%	20%	10%	14%
Three	25%	25%	10%	--	15%
Four	15%	--	5%	5%	6%
Five	5%	5%	10%	--	5%
Six	15%	--	5%	--	5%
Seven or More	15%	--	15%	--	8%
Functional Limitations:					
None	20%	25%	20%	25%	23%
Speech	5%	--	--	--	1%
Hearing	5%	20%	35%	20%	20%
Vision	25%	20%	35%	35%	29%
Walking	5%	25%	5%	35%	18%
Activities of Daily Living	60%	50%	55%	55%	55%
Needs Assistance to Leave Home	30%	45%	45%	25%	36%
Physical Illness/Conditions:					
None	10%	10%	10%	25%	14%
Arthritis	35%	15%	10%	15%	20%
Hypertension	30%	25%	25%	30%	28%
COPD	25%	25%	20%	20%	23%
Heart Disease	45%	30%	25%	40%	35%
Vascular Disease	25%	20%	25%	15%	21%
Cancer	20%	25%	15%	25%	21%
Diabetes	20%	15%	20%	25%	20%
Seizure	5%	5%	15%	5%	8%
Obesity	--	--	20%	25%	11%
CVA	10%	10%	15%	5%	10%
Alcohol Abuse	25%	15%	25%	10%	19%
Prescription Drug Abuse	--	5%	5%	--	3%
Glaucoma/Cataracts	20%	10%	15%	20%	16%
Tardive Dyskinesia	--	--	5%	--	1%
Hernia	10%	15%	10%	15%	13%
Thyroid	--	5%	15%	10%	8%
All Others	30%	30%	25%	15%	25%
Length of Psychiatric Illness:					
1-5 Years	10%	35%	15%	45%	25%
6-10 Years	--	15%	10%	50%	19%
11-20 Years	10%	25%	25%	5%	16%
21-30 Years	35%	20%	35%	--	23%
31-50 Years	45%	5%	15%	--	16%
No. of Prescription Medications:					
None	5%	5%	5%	25%	10%
One	5%	20%	15%	20%	15%
Two	15%	10%	15%	10%	13%
Three	20%	30%	30%	10%	23%
Four	25%	5%	20%	10%	15%
Five	30%	5%	15%	15%	16%
Six or More	--	25%	--	10%	9%

January 20, 1988

SPOKANE COMMUNITY MENTAL HEALTH CENTER

ELDERLY SERVICES

ORGANIZATION CHART


Board of Directors
Executive Director
Director, Elderly Services
Telephone Screeners
Respite Care
Coordinator
CMHC Psychiatrist
Family Medicine Physicians
Practicum Supervisor
Team Leader (Nurse) Geriatric Mental Health Spec.
Team Leader (Nurse) Geriatric Mental Health Spec.
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Students
Case Manager Case Manager Case Manager
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Table 4

1987

Elderly Services-Spokane Community Mental Health Center

Admissions to Multi-Disciplinary In-Home Assessment, Treatment and Case Management Program

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Totals	
Gatekeepers	22	23	24	14	22	19	16	31	17	19	11	21	238	37%
Relatives, Friends & Neighbors	16	9	6	8	4	6	8	9	4	7	12	7	96	15%
Physicians/Hospitals	11	14	8	7	8	10	11	15	9	8	7	8	117	18%
AAA Funded Programs	2	5	2	5	1	8	7	6	10	5	3	8	64	10%
Other Community Agencies	7	5	7	5	5	4	9	3	7	4	5	1	64	10%
Self	0	2	0	1	1	1	1	1	2	1	0	0	10	1%
Respite Transfers	2	11	9	2	8	0	2	6	5	0	2	3	50	8%
Total	60	69	55	42	51	48	54	71	54	44	40	51	639	

TABLE 5

MULTI-DISCIPLINARY IN-HOME EVALUATION TREATMENT &

CASE MANAGEMENT COMPONENT UTILIZATION OF OTHER COMMUNITY RESOURCES

SELECTED SERVICES UTILIZED IN 1987

Agency/Service	Case Management Clients Served Not an Unduplicated Count
Home Health (Nurses and Nurse Aides)	117
Chore Services - Remedy (Housekeeping & Meal Preparation)	206
Chore Services (Private Pay)	147
Day Health/Day Care	131
Congregate Nutrition (Meals & Socialization)	64
Meals on Wheels (Home Delivered)	137
Housing Placement and Home Repair	129
Respite Care	162
Transportation	241
Legal Services	91
Medicaid/Food Stamps	219
Hospitalization	81
Private Physicians	387
Residential Care Placement	79
Alzheimer Support Groups	109